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WHOLE WOMAN'S HEALTH, PETITIONER

v.

KIRK COLE, M.D.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

BRIEF OF EXPERTS IN HEALTH POLICY AS AMICI CURIAE IN SUPPORT OF PETITIONERS

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BRIEF OF EXPERTS IN HEALTH POLICY AS AMICI CURIAE IN SUPPORT OF PETITIONERS

Amici curiae respectfully submit this brief in support of Petitioners.[1]

INTEREST OF AMICI CURIAE

Amici are health policy experts and advocates who have been working for decades to strengthen the United States health care system's ability to deliver high quality care in a more efficient manner. Amici believe

[1] All parties have consented to the filing of this amicus curiae brief. No counsel for any party authored this brief in whole or in part, and no person or entity, other than amici curiae or their counsel, made a monetary contribution intended to fund the preparation or submission of this brief.

that the U.S. health care system must improve quality of care, health outcomes, patient experience, and patient access at the same time that it drives down costs. Amici have contributed to the development of wide-ranging initiatives that are underway across the nation in an effort to achieve these critical goals.

Amici include The National Partnership for Women & Families, Henry J. Aaron, Stuart Harold Altman, Robert A. Berenson, Donald M. Berwick, Linda J. Blumberg, Claire Brindis, David M. Cutler, Karen Davis, Judith Feder, Elliott S. Fisher, Paul B. Ginsburg, Sherry Glied, Bradford H. Gray, Frank Levy, Marilyn Moon, Joseph P. Newhouse, Robert D. Reischauer, Thomas Rice, Cathy Schoen, Neel Shah, and Katherine Swartz. Additional information about each amicus is set forth in the Appendix.

As experts in health policy, amici are knowledgeable about and have a strong interest in how government policy and regulation shape the delivery of medical services to patients. Amici respectfully submit that in evaluating whether the challenged provisions of Texas House Bill 2 (H.B. 2)[1] in fact further Texas' professed interest in promoting women's health, it is imperative for the Court to understand that the chal-

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[1] These include the "admitting privileges requirement," Act of July 12, 2013, 83d Leg., 2d C.S., ch. 1, 2013 Tex. Gen. Laws 5013, § 2 (H.B. 2) (codified at Tex. Health & Safety Code Ann. § 171.0031(a)(1)(A)) (reprinted at Pet. App. 182a-183a); 25 Tex. Admin. Code §§ 139.53(c)(1) (reprinted at Pet. App. 213a-214a), 139.56(a)(1) (reprinted at Pet. App. 215a), and the "ASC requirement," H.B. 2, § 4 (codified at Tex. Health & Safety Code Ann. § 245.010(a)) (reprinted at Pet. App. 194a); 25 Tex. Admin. Code § 139.40 (reprinted at Pet. App. 203a-209a).

lenged mandates—that abortion services in Texas now must take place in facilities meeting Ambulatory Surgical Center criteria, and that a physician must have admitting privileges at a hospital within 30 miles of the facility in which the abortion takes place—are fundamentally out of step with the national drive toward making high quality care more accessible and less costly.

INTRODUCTION AND SUMMARY

Americans benefit from some of the most expensive and most sophisticated health care in the world, but it is no secret that the country's health care system as a whole fails to deliver optimal care. More expensive health care does not necessarily deliver better health outcomes. Many forms of care are provided in ways that are unnecessarily costly, driving up health care expenditures without any meaningful improvement in health outcomes. The net result not only wastes scarce health care dollars, but also degrades the quality of patient care.

Physicians, hospitals, patient advocates, employers, insurance companies, health policy experts, and government leaders from across the political spectrum are in substantial agreement that, to deliver optimal health outcomes and be sustainable in the long run, the health care system must find ways to deliver high quality care to more people more efficiently. Numerous initiatives within the public and private sectors aim to achieve these goals. Payment reforms that reward doctors and hospitals for improved health outcomes, rather than for the mere provision of more (and more costly) care, are one example. Another example is "delivery system reform," which includes the establishment of more con-

venient and more cost-effective sites of care in order to increase the accessibility of quality care. Texas itself has been home to some of these payment and delivery system initiatives.

The Texas abortion restrictions at issue in this case contrast starkly with the overall national trend toward improving patient access and overall health outcomes while reducing unnecessary health care costs. As the national trend moves to shift care out of higher-cost settings and to encourage patients to obtain, and practitioners to provide, high-quality medical care at more accessible and cost-effective sites, H.B. 2 does just the opposite. H.B. 2 raises the cost of care with no documented benefit to those affected. It restricts abortion services to fewer and unnecessarily expensive facilities, and it reduces the number of physicians who may provide abortion services. The result is increased cost and decreased patient access to a constitutionally protected medical procedure. While Texas alleges that H.B. 2 will improve health outcomes for those patients who manage to receive abortion services, the fact that H.B. 2 is so discordant with the national trend in delivery system reform should cause the Court to cast a very skeptical eye on a policy based on the odd proposition that increasing the cost of care and decreasing access to care will improve women's health.

ARGUMENT

I. THERE IS WIDESPREAD CONSENSUS THAT HEALTH CARE SYSTEM REFORM IS NECESSARY TO ACHIEVE HIGHER QUALITY, LOWER COST HEALTH CARE

The United States is home to some of the best doctors, most innovative medical companies, and highest

quality medical care in the world. Yet in light of the gap between the costs of the U.S. health care system and the overall quality of care (taking into account factors such as access to quality care, patient experience, and health outcomes), a broad coalition has embraced the need for health care system reform.

The costs of health care in the U.S. are higher than anywhere else in the world.[3] Health care spending in the United States accounts for 17.1% of the nation's Gross Domestic Product (GDP). Estimates project that the percentage will grow to 19.6% of GDP in 2024.[4] The United States devotes at least 50% more of its national income to health care than do other nations.[5] Indeed, the United States spends significantly more per capita than the ten other richest countries in the world.[6]

At the same time, by most metrics U.S. health care

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[3] David Squires & Chloe Anderson, *U.S. Health Care from a Global Perspective: Spending, Use of Services, Prices, and Health in 13 Countries*, *The Commonwealth Fund*, Issues Int'l Health Policy (Oct. 2015).

[4] CMS, *National Health Expenditure Projections 2014-2024* 1 (2014), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads /proj2014.pdf .

[5] Karen Davis et al., *Mirror, Mirror on the Wall, 2014 Update: How the U.S. Health Care System Compares Internationally*, The Commonwealth Fund 9 (June 2014), http://www.commonwealthfund.org/~/media/files/publications/fund-report/2014/jun/1755_davis_mirror_mirror_2014.pdf; Squires & Anderson, note 3, *supra*, at 2.

[6] Davis, note 5, *supra*, at 5; Squires & Anderson, note 3, *supra*, at 3.

outcomes lag behind those of peer countries.[7] The U.S. achieves poorer health quality measures than almost all peer high-income countries, including Australia, Japan, and the United Kingdom.[8]

A broad group of stakeholders—ranging from federal, state, and local governments, to employers, health care providers, patient advocates, and health policy experts—is actively engaged in developing and implementing reforms that enable high quality care to be delivered to more patients at a lower cost without compromising (and, indeed, improving) patient experience.[9] The coalition is broad and deep, uniting unlikely allies.

Business leaders nationwide have been strong proponents for health care system reform.[10] In 2000, leaders from major U.S. companies founded the Leapfrog Group, a membership organization working toward a higher quality, lower cost health care system.[11] Their membership includes Fortune 500 companies as well as

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[7] Davis, note 5, *supra*, at 5; Squires & Anderson, note 3, *supra*, at 3.

[8] *U.S. Health in International Perspective: Shorter Lives, Poorer Health* 1-2 (Steven H. Woolf & Laudan Aron eds. 2013).

[9] Partnership for Sustainable Care, *Strengthening Affordability and Quality in America's Health Care System* (Apr. 2013), http://www.rwjf.org/content/dam/farm/reports/reports/2013/rwjf405432.

[10] See, *e.g.*, National Business Group on Health, *About Us*, https://www.businessgrouphealth.org/about/index.cfm (last visited Dec. 30, 2015); National Business Coalition on Health, *About Us*, http://www.nbch.org/About-NBCH (last visited Dec. 30, 2015).

[11] Leapfrog Group, *About Leapfrog*, http://www.leapfroggroup.org/about_leapfrog (last visited Dec. 30, 2015).

national and regional purchaser organizations—such as the National Business Group on Health, the Pacific Business Group on Health, the Midwest Business Group on Health, and the Mid-Atlantic Business Group on Health—which in turn represent major regional corporations.[12] The Leapfrog Group now represents companies with a combined 34 million U.S. employees and $62 billion in health care spending.[13] Likewise, the Business Roundtable, a national group of Chief Executive Officers, has called for changes to the way health care is delivered and paid for.[14] A recent Business Roundtable report explains that "our nation needs to address the long-term fiscal challenges affecting both publicly funded health care programs and employer-sponsored health insurance coverage."[15]

Patients and health care consumers similarly support the need for health system transformation. For example, the Consumer-Purchaser Alliance—a coalition including major consumer advocacy organizations, Fortune 500 employers, and some of the nation's largest labor unions—bridges the interests of consumers (pa-

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[12] *Ibid.*

[13] Leapfrog Group, *Leapfrog Members*, http://www.leapfroggroup.org/for_members/who_are_members (last visited Dec. 30, 2015).

[14] Business Roundtable, *About Us Executive Committee*, http://businessroundtable.org/about/executive-committee (last visited Dec. 30, 2015).

[15] Business Roundtable, *Driving Innovation in the Health Care Marketplace: A CEO Report* 1 (Sept. 2014), http://businessroundtable.org/sites/default/files/0_healthcare/BRT-Health-Care.pdf.

tients) and purchasers (businesses) by advocating for a high-quality, lower cost health care system. And organizations such as the American Association of Retired Persons include "transforming our health care system"—by expanding access, lowering costs, and increasing quality—as among their top policy priorities.[16] Medical providers likewise support health system reform. The American Medical Association (AMA) and the American College of Physicians, for example, have advocated for delivery system and health care payment reforms.[17]

The goals of controlling health care costs while improving quality have also united political leaders from both sides of the aisle. As a report from the Bipartisan Policy Center put it: "[W]e must simultaneously address shortfalls in the quality and efficiency of care that lead to higher costs and to poor health outcomes."[18]

In sum, there is broad agreement across constituencies that we should foster the provision of more effi-

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[16] AARP, *The Priorities Book: Building a Better Future 2015-2016* 11, http://www.aarp.org/content/dam/aarp/about_aarp/aarp_policies/2015-05/AARP-Priorities-Book-2015-2016.pdf.

[17] See, *e.g.*, American Med. Ass'n, *A Guide to Physician-Focused Alternative Payment Models*, https://download.ama-assn.org/resources/doc/washington/alternative-payment-models-physician-guide.pdf; American Med. Ass'n, *Creating Thriving Physician Practices*, http://www.ama-assn.org/ama/pub/about-ama/strategic-focus/physician-practices/steps-forward.page; American College of Physicians, *Reforming Physician Payments To Achieve Greater Value In Health Care Spending* (2009), https://www.acponline.org/advocacy/current_policy_papers/assets /reforming_pp.pdf.

[18] Bipartisan Policy Center, *Improving Quality and Value in the U.S. Health Care System* i (2009).

cient, higher quality care through policy and practice, with the ultimate goal of a healthier American public and a sustainable health care system.

II. Health Policy Reforms Are Improving Quality, Accessibility, and Health Outcomes While Lowering Costs

Private sector leaders and policymakers are working together on many fronts to address health care costs, quality, access, outcomes, and patient experience. Their efforts, including those in Texas, have focused on two types of reform: payment reform and delivery system reform. No single mechanism of payment or delivery system reform will necessarily achieve all of the consensus goals, described above, for improving health care in the United States. But taken together, the transformation of the way we pay for and deliver health care is essential to advance the interests of improving health care in the United States.

A. A Diverse Set of Payment Reforms Provides Incentives to Improve Quality, Access, and Outcomes While Controlling Costs

In an effort to drive toward higher quality care at reduced cost, payment reforms have focused on moving away from the traditional fee-for-service (FFS) payment approach to alternative value-based models. Under the FFS model, a health care provider bills a payer for each item of care provided. The FFS system does not reward or pay for patient outcomes or quality care. Instead, FFS rewards quantity over quality, which gives health care providers a perverse incentive to deliver more services than are medically necessary (and in some instances more than are medically safe).

The "value-based" payment approach aims to change that. Value-based payment shifts incentives so that providers are rewarded for efficient, quality care. In some models of value-based payment, payment is made for an episode of care,[19] or a period of care, or for a set of services for a population. Providers either receive a fixed fee, or arrangements are established through which providers and payers share in the savings that are achieved from providing improved, outcome-based care. Value-based payment models are designed to provide incentives for full utilization of lower-cost settings to provide quality, effective care. Under a fixed global or bundled payment, health care organizations have an incentive to use lower-cost personnel and provide care in lower-cost settings of comparable quality.

Both the public and private sectors are implementing these value-based approaches to paying for health care. Recently, the U.S. Department of Health and Human Services (HHS) announced goals to shift 30% of Medicare payments to alternative payment models tied to quality or value by the end of 2016, and 50% of payments by the end of 2018.[20] State governments and

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[19] An episode of care refers to a series of health care services relating to a specific condition or illness, often provided by multiple providers across different settings.

[20] Sylvia M. Burwell, *Setting Value-Based Payment Goals—HHS Efforts to Improve U.S. Health Care*, 372 N. Engl. J. Med. 897, 897 (2015).

commercial insurers are following suit, also moving to value-based payment approaches.[21]

One prominent alternative payment model, the Accountable Care Organization (ACO), involves a coordinated set of providers that "work together and accept collective responsibility for the cost and quality of care delivered to a population of patients."[22] ACOs coordinate care across health care settings and different types of providers. The manner in which ACOs are paid aims to provide an incentive to move away from inefficient, low quality care.

Texas itself has seen the adoption of ACO models. For example, the Houston-based Accountable Care Coalition of Texas serves approximately 70,000 Medicare beneficiaries,[23] and in the Dallas Fort Worth area, leading health care entities joined together in 2015 to create an ACO called "Forward Health Partners,"[24] with goals

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[21] See, *e.g.*, The Kaiser Commission on Medicaid and the Uninsured, *The State Innovation Models (SIM) Program: A Look at Round 2 Grantees*, http://files.kff.org/attachment/fact-sheet-the-state-innovation-models-sim-program-a-look-at-round-2-grantees (Sept. 2015) (states); Karen Ignagni, *Innovation in Plain Sight*, 21 Am. J. Managed Care 172b (Mar. 20, 2015) (commercial insurers).

[22] Council of Accountable Physician Practices, *Accountable Care Glossary of Terms*, http://accountablecaredoctors.org/what-is-accountable-care/accountable-care-glossary-of-terms/ (last visited Dec. 29, 2015).

[23] *100 Accountable Care Organizations to Know*, Becker's Hospital Rev. (Sept. 23, 2015), http://www.beckershospitalreview.com/lists/100-accountable-care-organizations-to-know-2015.html.

[24] Texas Health Resources, *Five Leading North Texas Health Care Systems Announce Launch of 'Forward Health Partners'* (Apr. 20, 2015), https://www.texashealth.org/news/five-leading-

of improving access to care[24] and lowering the cost of care by "creating efficiencies that benefit patients."[25]

Another value-based payment approach involves bundled payments, a single reimbursement for all of the different services required to care for a given medical condition or procedure. This approach is designed to increase accountability for quality and cost across providers and settings by reimbursing for a complete episode of care. Several bundled payment models are in place in Texas. One prominent pilot project focuses on improved cancer treatment. After a successful pilot test of bundled payments for cancer care, UnitedHealthcare has decided to expand the test in Texas, Florida, and several other states. In the initial test, the company reported that overall costs for treatment dropped by 34% even as spending on chemotherapy drugs rose significantly.[27]

These different types of payment reforms need not work in isolation. Texas is one of six states, for example, to implement a Delivery System Reform Incentive Payment (DSRIP) program, a performance-based in-

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north-texas-health-care-systems-announce-launch-of-forward-health-partners.

[24] The ACO boasts of "one of the largest and most convenient networks." *Ibid.*

[25] *Ibid.*

[27] Julie Appleby, *UnitedHealthcare Expands Effort to Rein In Rising Costs Of Cancer Treatment*, Kaiser Health News (Oct. 29, 2015), http://khn.org/news/unitedhealthcare-expands-effort-to-rein-in-rising-costs-of-cancer-treatment/.

centive program for Medicaid patients.[28] The goals of the Texas DSRIP program are "to incentivize hospitals and other providers to transform their service delivery practices to improve quality, health status, patient experience, coordination, and cost-effectiveness."[29] The Texas DSRIP initiative allocates funds across hospitals, clinics, and other providers to promote value-based quality care.[30]

B. Delivery System Reforms Recognize that More Flexible and Accessible Locations of Care Improve Quality and Reduce Costs

As value-based payment reforms create incentives to provide more efficient and higher quality care, health care providers are implementing a variety of changes in the way care is actually delivered. Although these delivery system reforms have many dimensions, to a large extent they are directed at allowing patients to obtain high-quality care in ways that are more accessible and patient-centered and that can decrease, rather than increase, the overall costs of the health care system.

Delivery system changes are wide-ranging, but include some of the following types of measures:

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[28] Alexandra Gates et al., *An Overview of Delivery System Reform Incentive Payment (DSRIP) Waivers*, The Henry J. Kaiser Family Foundation, The Kaiser Commission on Medicaid and the Uninsured (Oct. 2014), http://files.kff.org/attachment/an-overview-of-dsrip.

[29] Texas Health and Human Services Commission, *Waiver Overview*, http://www.hhsc.state.tx.us/1115-Waiver-Overview.shtml (last visited Dec. 30, 2015).

[30] *Ibid.*

- Redesign of primary care offices into Patient Centered Medical Homes (PCMHs), which move away from care "silos" by using a team approach to care, coordinating care across physicians, hospitals, specialists, and home health, and enhancing access through expanded hours and use of information technology.[31] In Texas, consistent with the DSRIP goals, the state legislature has required the Texas Health and Human Services Commission to promote PCMHs for Medicaid patients.[32]
- The use of case management nurses to manage the care of complex patients with multiple chronic diseases.[33]
- A greater use of data analytics to identify patient risks and needs.[34]
- The integration of evidence-based best practices into inpatient and outpatient workflow.[35]

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[31] American Hospital Ass'n, *Patient-Centered Medical Home, American Hospital Association Committee on Research, American Hospital Association* 2 (Sept. 2010).

[32] Health and Human Services Commission, *Texas Medicaid Patient-Centered Medical Home Report* 1-2 (Dec. 2013), http://www.hhsc.state.tx.us/reports/2013/SB7-Medicaid-Patient-Centered.pdf.

[33] Patricia Thomas, *Case Management Delivery Models: The Impact of Indirect Caregivers on Organizational Outcomes*, 39 J. of Nursing Admin. 30 (Jan. 2009).

[34] Wullianallur Raghupathi & Viju Raghupathi, *Big Data Analytics in Healthcare: Promise and Potential*, Health Information Science Systems (2014), http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4341817.

- The advent of pharmacy clinics and urgent care centers to improve access while decreasing the cost of care.[36]
- Various forms of telemedicine—the use of telecommunications and information technologies to enable the provision of medical care from a distance[37]—which can help facilitate regular communication between providers and patients, as well as remote monitoring in patients' homes. These can lead to lower hospital utilization rates and significant cost savings.[38]

As this summary list indicates, when doing so would not compromise (and could even improve) the

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[36] Ronald A. Paulus et al., *Continuous Innovation in Health Care: Implications of the Geisinger Experience*, 27 Health Affairs 1235 (Sept. 2008), http://content.healthaffairs.org/content/27/5/1235.full.

[37] Ateev Mehrotra, *The Convenience Revolution for Treatment of Low-Acuity Conditions*, 310 J. Am. Med. Ass'n 35 (2013).

[37] Intel, *Transforming Healthcare with Telemedicine Solutions based on the Internet of Things (IoT)* (2014), http://www.intel.com/content/www/us/en/internet-of-things/blueprints/iot-dell-telemedicine-blueprint.html?wapkw=telemedicine.

[38] For example, a 2008 study by the New England Healthcare Institute found that remote patient monitoring resulted in a 60% reduction in hospital readmissions compared to standard care and a 50% reduction in hospital readmissions compared to disease management pro-grams without monitoring. The same study found that the potential reduction in readmissions from remote patient monitoring would save up to $6.4 billion dollars per year. New England Healthcare Institute (NEHI), *Research Update, Remote Physiological Monitoring* 1 (Jan. 21, 2009), http://www.nehi.net/publications/45-remote-physiological-monitoring-research-update/view.

quality of care, stakeholders have sought to shift care away from hospitals and other "high-overhead" facilities and toward alternative, lower-cost sites. Because lower cost does not equal less care—but rather can result in greater access to high quality care delivered more efficiently and more conveniently—overall health care outcomes are improved even as health care expenditures are reduced.

One way to view this trend is to conceive of the various sites for providing health care as points along a continuum running from low-cost settings at one end to very high-cost settings at the other. At the low-cost end of the continuum, a person is able to obtain medical care or advice at home and on the high-cost side a patient must be admitted into a hospital for care. The trend in health care delivery reform is to develop policies, practices, and technologies that enable patients to shift down along that continuum.[20] This shift reflects the recognition that high quality care can be delivered in lower-cost settings, improving patient access and, therefore, overall health outcomes all while bending the cost curve.

And indeed, fueled by technological improvements and honed evidence-based practices, a substantial shift has occurred over the last several decades from inpatient, hospital-based settings to a broad spectrum of

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[20] Intel White Paper, *Intel's Approach to Innovation and Healthcare* 3 (June 14, 2007), http://www.intel.com/pressroom/kits/healthcare/HRI_whitepaper.pdf; Karen Davis et al., *Innovative Care Models for High-Cost Medicare Beneficiaries: Delivery System and Payment Reform to Accelerate Adoption*, 21 Am. J. of Managed Care e349, e351 (2015).

outpatient care at freestanding and community based clinics. The number of common procedures, including surgical procedures, performed in freestanding outpatient clinics and office settings reflects this continuing trend in health care delivery. In fact, the number of outpatient procedure visits in the United States increased from about half of all surgery visits in 1996 to nearly two thirds of all surgery visits in 2006.[40] The migration of care to lower-cost practice environments that optimize quality care, affordability, and efficiency has been shown to benefit patients. For instance, as common gynecological and obstetric procedures have shifted to office-based settings, proven safety and improved patient experience have resulted.[41]

The same trends are happening in Texas, where leaders are recognizing that in many situations it is appropriate to provide medical care in more accessible and cost-effective settings. Many procedures performed in Texas that are more complex than abortion care are not required to be provided in an Ambulatory Surgical Center or hospital. In fact, Texas law explicitly allows properly trained and certified physicians to perform major outpatient surgeries, including some that require general anesthesia, in their offices, which are not subject to ASC regulations. See 22 Tex. Admin. Code § 192.1-192.6.

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[40] Karen Cullen et al., *Ambulatory Surgery in the United States, 2006*, 11 Nat'l Health Statistics Reports 5 Fig. 1 (Sept. 4, 2009 rev.).

[41] See, *e.g.*, Richard Urman et al., *Safety Considerations for Office-Based Obstetric and Gynecologic Procedures*, 6 Rev. Obstet Gynecol. e8, e9 (2013) (citing advantages for patients including "patient satisfaction").

III. The Challenged H.B. 2 Provisions Are Fundamentally Out Of Step With Policies That Promote Better Health Care

The types of payment and delivery reform described above, which are underway in Texas and across the country, move toward making quality care more accessible to patients, while avoiding wasteful or unnecessary care and expense. Given the strong consensus among health policy experts, patient advocates, health care providers, public officials, and business leaders, on the imperative to reform and strengthen the U.S. health care system to improve quality and value, further health care policy reforms must continue to move in this direction.

In contrast, new health care regulations that cut the other way—that require unnecessary or unnecessarily expensive care, limit patient access, or make the patient experience more difficult, without improving quality or outcomes—hinder these critical efforts to put the U.S. health care system on a stronger footing.

The national trend toward delivering high quality care at a lower cost, including through the use of more flexible and cost-efficient sites of care, demonstrates that it would be inappropriate for the Court to reflexively assume that H.B. 2's channeling of abortion services to fewer, more expensive facilities, with fewer available physicians, will in any way improve the quality of care and overall health outcomes for women.

The onerous requirements of H.B. 2 and their troubling consequences are set forth in detail in other briefs, so amici need not dwell on them here. But amici wish to highlight a few ways in which the challenged provisions of H.B. 2 are incompatible with ongoing im-

peratives toward improving health care in the United States.

First, contrary to the national effort to move care toward lower-cost settings that provide an equal or greater level of quality, H.B. 2 would needlessly force a common medical procedure into a higher-cost setting. Instead of the office- and clinic-based settings where high quality services are currently being provided, the ASC requirement would force care into multi-million dollar facilities that are intended for complex and higher-risk surgical procedures. In so doing, H.B. 2 makes unnecessarily high-cost care the only option for patients—exactly the type of perverse policy incentive that health care leaders are working to eradicate in order to achieve a 21st century health care system.

Second, while some types of medical and surgical procedures may require higher-cost settings, that is not the case here, as the leading medical associations in the relevant field have explained. See American College of Obstetricians and Gynecologists et al. Amici Br. Abortion care does not entail invasive surgical techniques and has achieved an exemplary safety record for decades in office and clinic settings. *Id.* at 6-9. According to the nation's leading medical organizations, the Texas restrictions "are contrary to accepted medical practice and are not based on scientific evidence. They fail to enhance the quality or safety of abortion-related medical care." *Id.* at 4.

And third, the H.B. 2 restrictions are at odds with the national drive toward improved access to care and a better patient experience. Both challenged restrictions deprive patients of qualified health care providers. They thus dramatically reduce the availability of an

important health care service. In doing so, they erode the patient experience and limit access by forcing patients to travel farther and wait longer to obtain necessary care.

At a time when the public and private sectors are transforming the way that health care is delivered in this country—eliminating unnecessary and costly tests and procedures, thinking judiciously about every health care dollar, and promoting numerous initiatives to incentivize higher-value care and expanded access to qualified health care providers—H.B. 2 moves in the wrong direction.

By forcing care into unnecessarily high-cost settings, and layering medically unnecessary burdens on health care providers, the H.B. 2 restrictions cannot be reconciled with consensus efforts underway to strengthen the U.S. health care system and improve the quality and availability of health care. This fundamental mismatch between the challenged provisions of H.B. 2 and nationwide imperatives for health care delivery system reform reinforces the conclusion that these regulations do not advance an interest in promoting women's health.

CONCLUSION

For the foregoing reasons, the decision below should be reversed.

Respectfully submitted,

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APPENDIX

APPENDIX

AMICI CURIAE INFORMATION

The National Partnership for Women & Families believes that all women and families should have access to quality, affordable health care, and has been at the forefront of advancing change in our health care system. Over the last 15 years, the National Partnership has honed a set of best practices for engaging and supporting patients, families, and consumer advocates in a wide variety of multi-stakeholder health care initiatives including quality improvement, health system and practice redesign, payment reform, performance measurement, public reporting, and research. The National Partnership leads the Coalition for Better Care, a coalition of 80 national and state consumer organizations that focuses on health care quality improvement and patient-and family-centered delivery system reform. The National Partnership President also co-chairs the Consumer-Purchaser Alliance, a national, multi-stakeholder coalition advocating for higher quality, more affordable, patient-centered health care on behalf of consumers (those who get care) and purchasers (those who pay for care).

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Judith Feder, Ph.D., is a professor and founding dean of Georgetown University's McCourt School of Public Policy and an Urban Institute Fellow. She has published widely on how best to promote affordable health insurance coverage, most recently exploring payment reform strategies associated with the Affordable Care Act. Feder is a former Department of Health and Human Services principal deputy assistant secretary and a member of the National Academy of Medicine.

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Cathy Schoen, M.S., is a health care and policy economist with over 30 years of experience working on federal, state and local health care and policy issues. Until her retirement, she was Senior Vice President of Policy, Research and Evaluation at the Commonwealth Fund, a nonpartisan nonprofit foundation based in New York. She was a Brookings Fellow and served in the Carter Administration during the 1970s.

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